CHRISTOPHER WAYNE LESTER
MADISON MEDICAL GROUP
RECORDS
14-L

back and nerves didn't bother me. I don't know why I am living. I feel I can't do anything". His ambitions for the future are to stay comfortable.

MENTAL STATUS EXAMINATION: The mental status examination is a face to face examination between the psychiatric patient and the physician. The purpose of this examination is to determine the functions of the elements of mental and brain activity. Thought is also examined to determine the presence or absence of circumstantial thinking, looseness of associations, or other detriments of abnormal mental functioning. Content of thought is examined for delusional thoughts, morbid ideas, perceptual distortions, suicidal or homicidal ideation, or other signs of mental pathology. Language is examined for expressive and receptive function, repetition errors, and to determine if the patient can properly take mental ideas and convert them to motor acts.

Orientation to person, place, and time is determined. Gross memory ability is determined. Evaluation of the mental stream of activity, mood, range of affect, thought, and motor speed is completed. The mental status examination is a qualitative examination and quantified elements of the mental status examination are determined by standardized mental assessment.

Appearance/Behavior/Attitude: Mr. Lester was an obese caucasian male, well groomed with beard and mustache and ball cap. He had a cane in his right hand. He was pleasant with broad affect.

Speech and Language: Fluent, coherent, goal directed.

Mood and Affect: Mood was described as depressed secondary to pain. Affect had some qualities of depression but at times was broad with appropriate smiling and pleasantries.

Thought Process/Thought Content/Perception: Thought process was logical and sequential. Thought content showed passive suicidal ideation, lack of homicidal ideation and lack of delusional belief system. Perceptional examination was unremarkable.

Sensorium and Cognition: There was no evidence of gross cortical dysfunction with attention, concentration, immediate short term or long term memory.

Insight and Judgment: The patient has limited insight to the extent or lack thereof of his physical injury and his current hopelessness regarding rehabilitation. Judgment is overall deemed fair and appropriate.

STANDARDIZED MENTAL ASSESSMENT/PSYCHOLOGICAL TESTING: John D. Justice, M.D. requested formal psychological testing. These tests were under the direction of Peggy Casdorph, RN, MA, Licensed Psychologist. Medical conclusions about these data were made by John Justice, M.D.

Standardized means the administered test instruments had exact rules for test administration and exact rules for test scoring. These rules have been validated, standardized, and published, and are expected to be utilized by any person performing or interpreting the following instruments.

The MMPI-II profile was obtained and analyzed. Profile was valid with some tendencies for the claimant to deny common human frailties and a resultant pattern indicative of chronic personality disturbance. Individuals with this profile often do not benefit from experience. They have a tendency to be passive dependent and lack assurance. Depression and apathy are generally characteristics of individuals with this profile. He is likely to experience problems with relationships. He is apt to express hostility indirectly. Patients with this profile tend to be over-concerned about body functioning and acknowledge a large variety of complaints which are generally vague and have pain without a clear organic basis. When documented medical problems do exist, exaggeration of symptoms is likely.

Mr. Lester achieved a full scale IQ of 90, performance IQ of 103 and verbal IQ of 81. This was a significant change from his previous intellectual functioning testing of April 9, 2001. He received a high school achievement level in reading, 5th grade in spelling and 8th grade in arithmetic. On the CARB, WMT and Rey testing he achieved good efforts. That is, there is no indication of malingering, though the testing does indicate that the claimant has a tendency to exaggerate physical symptomatology when under periods of stress.

REVIEW OF SPECIFIC MEDICAL/PSYCHIATRIC RECORDS: Psychiatric records were reviewed in their entirety as provided by the claimant.

03/10/00 he claimant was injured when he fell backwards after the hood of he truck knocked his off while changing oil. He fell approximately five feet hitting another truck and landing on his left side. He states a positive LOC and being dazed for approximately 45 minutes. He was taken to CAMC ER where multiple films were taken and read as being negative. He was released from the ER and is the follow-up with corporate health.

03/14/00 Follow-up with Dr. Bailey with complaints of nausea and some drainage from his left ear along with pain in his neck and left shoulder. Dr. Bailey contacted Dr. Apple who recommended that the claimant follow-up with an ENT to determine if he had a fracture of the temporal bone. He was diagnosed with a cerebral concussion and treated conservatively.
03/15/00 Seen by Dr. Phillips who did an Audiogram which showed some hearing loss bilaterally but no fractures He did not find any direct injury to the ear of internal canal and no drainage was noted.

03/21/00 MRI of the left shoulder this was reported to be negative.

03/22/00 Seen by Dr. Bailey with continued complaints of headache and neck and left shoulder pain. Physical therapy was started.

03/27/00 Seen by Dr. Bailey wit continued complaints of neck and shoulder pain along with headaches.

Change of physician to Dr. Snyder (Saw the claimant in the past for an injury to the dorsal area with a possible T11-12 fracture. The claimant received an 11% impairment award and missed three years of work)

Released to light duty work. Referred to rehab services on 04/02/00

04/07/00 Seen by Dr. Snyder for pain in his neck, left shoulder. He is on Motrin, flexeril, and vicodin.

04/10/00 Claim changed to include head injury, cervical, thoracic and lumbar strain.

04/18/00 a letter from his employer states that they have no light duty positions.

04/26/00 Seen by Dr. Snyder with complaints of neck and shoulder pain and also left knee pain. Vicodin was approved and additional physical therapy was recommended.

06/19/00 Seen by Dr. Snyder with increased pain in the shoulder and neck which has worsened with physical therapy. Physical therapy stopped and orthopedic consult obtained.

07/10/00 Seen by Dr. Snyder with same complaints. To continue medications

07/17/00 Seen by Dr. Snyder for continued complaints of neck and left shoulder pain. Consult to Dr. Loimil made.

08/17/00 Seen by Dr. Loimil who requested another MRI of his left shoulder. He indicated that he would take the claimant on as a patient but for some reason he never went back or saw Dr. Loimil again.

08/30/00 X-rays of his left should and AC joint were done and read as being normal.

09/12/00 MRI of the cervical and lumbar spine were performed and read as negative for disc herniation.

10/02/00 NCS of his upper extremities performed by Dr. Pratt were also negative.

10/06/00 Seen by Dr. Amores with complaint of pain in his neck going down his left arm. It was felt that he had musculoskeletal strain involving his neck and lower back without neurological deficit. He should continue conservative treatment.

11/27/00 Seen by Dr. Snyder and a pain clinic evaluation was recommended as well a psychiatric consultation and follow-up with Dr. Settle.

11/29/00 MRI of the left shoulder authorized.

12/22/00 Seen by Dr. Mir for an IME who requested additional follow-up wit Dr. Loimil and a pain clinic consultation and follow-up.

01/08/01 Rehab closed by compensation

01/30/01 Repeat MRI of the left shoulder performed and showed no evidence of rotator cuff tear or any other acute pathology. X-rays of his shoulder with and without weights were negative.

02/28/01 Seen by Dr. Saldahna at the pain clinic. He was noted to have generalized neck and low back

pain. He was neurologically intact. He was diagnosed with lumbar arthopathy and cervical strain. He recommended facet joint injections for his lower back and trigger point injection for his neck. He recommended a follow-up with Dr. Loimil for his shoulder pain.

03/02/01 He saw Dr. Snyder and the orthopedic consult is changed to Dr. Surface.

04/09/01 Seen by Dr. Riaz at the Bluefield mental health clinic with verbalization of symptoms of depression and anxiety this reported to have started after his injury in March of 2000. He verbalized feeling of irritability, and upsetting easily as well as crying spells. On examination the claimant appeared depressed and nervous his mood was depressed and affect was anxious. Speech was not spontaneous. He admitted to fleeting thoughts of suicide but no plans. He verbalized a decrease in pleasurable activities such as sex and his marriage is reported to be without problems. His general knowledge was adequate. Recent and remote memories were intact attention and concentrations were fair and insight and judgment were present. The dianosis given were: AXIS I:Major depressive Disorder, single, severe without psychotic features, Generalized Anxiety Disorder. AXIS II: Borderline Intellectual functioning. AXIS III: Recurrent headaches, severe and chronic back pain, obesity.
"It is my professional opinion that due to the severity of his psychiatric symptoms coupled with his physical problems he is unable to sustain gainful employment at this time".
He suggests that the claimant receive bi weekly psychotherapy sessions for the next six months and take pamelor 25 mg one time a day. He will need this pain medication reduced gradually.

06/26/01 Seen by Dr. Mir for an IME he was found to have A) Cervicodorsal and left scapular strain with cervical root irritation B) Lumbosacral strain C) sprain left shoulder and AC joint D) blunt trauma left rib cage E) sprain left knee F) cerebral concussion. He has reached maximum degree of medical improvement and is NOT totally disabled. He recommends vocational follow-up and a FCE is recommended is Ok'd by his attending physician. Using a ROM model he qualifies for 20% whole man impairment. And is not expected to be progressive.

DIAGNOSIS:

AXIS I: Depressive disorder NOS.

AXIS II: Dependent personality traits, **no indication of borderline intellectual functioning, previous results of intellectual testing are of an unclear basis, i.e. exaggerated, malingered, or inadequately measured.**

AXIS III: Lumbosacral strain, history of left shoulder sprain, left knee sprain, status post cerebral concussion fully resolved.

AXIS IV: Stressors due to unemployment and change in financial and occupational status.

AXIS V: GAF 65.

400 Division Street, Suite 14
So. Charleston, WV 25309

304-766-4421
Fax 804-766-4461
Jjusticemd@aol.com

OPINIONS/REASONING/CONCLUSIONS:

Diagnosis/Presence of Disorder: The claimant has a diagnosis of a depressive disorder not otherwise specified. Specifically this includes symptoms of irritability, insomnia, appetite fluctuation, passive suicidal ideation and crying spells. He also manifests dependent personality traits and a tendency to regress under periods of stress. Based on historical information, current presentation and psychological testing when documented medical problems do exist exaggeration of symptoms is likely. Physical symptoms serve a basis for secondary gain in the form of attention from others, freedom of responsibility and regression.

Preexisting/Aggravating Factors: Mr. Lester has a history of interpersonal difficulties including divorce and marital counseling. He has a history of a physical injury with three years of unemployment secondary to such.

Natural Course of Illness: We would not expect further improvement in the claimant's condition unless he has improvement in his perception of physical pain and a return to some sort of occupational or vocational functioning to improve his overall sense of self.

The Role of Malingering/Symptom Exaggeration/Secondary Gain: The claimant exhibits symptoms of symptom exaggeration in which physical symptomatology serve a role for underlying secondary gain purposes.

Causation/Compensability/Proximate and Direct Causation Secondary to the Injury: The claimant was injured on 03/10/00. He has seen Dr. Riaz Riaz since April 9, 2001. He reports symptoms of depression secondary to chronic pain, lack of occupational and social functioning, and marital discord. Mr. Lester reports little benefit with psychiatric and psychological intervention. Based on physical evaluations (Dr. Mir 06/26/01) the claimant experienced strain/sprain injuries without evidence of disc herniation or nerve impingement. It was felt he had reached maximal degree of physical improvement and was not disabled, being a candidate for vocational rehabilitation and/or an FCE evaluation. Given the above, the claimant's psychiatric diagnosis is partially causally related.

Maximum Medical Improvement/Percentage of Psychiatric Impairment: The claimant is at maximum medical improvement from a psychiatric perspective. We would not expect further significant improvement in his condition. Based on the AMA Guidelines and West Virginia Workers' Compensation Guidelines his level of psychiatric impairment would be on the order of 10% psychiatric. That is a mild or noticeable impairment in functioning, Class II of the AMA Guidelines.

Treatment Adequacy/Recommendations for Treatment: The claimant's dosage of Effexor should be adjusted to a more therapeutic regimen. As long as the claimant has a perception of himself as significantly disabled and impaired (although it is unclear that this is objectively the reality of the situation) he will continue to experience significant dysphoria and a propensity of chronic suicidal ideation.

Prognosis/Psychiatric Restrictions: This physician is certainly in disagreement with the previous evaluation and Social Security findings for the claimant. He does not manifest a psychiatric condition that would prevent him from working at jobs he has held in the past or in retraining activities. He does not have

a major mood disorder requiring chronic psychiatric hospitalization, a psychotic disorder, a significant cognitive disorder, or any other condition that is directly related to his work injury. His extent of psychiatric pathology is just as much secondary to personality issues and difficulty understanding and coping with pain and occupational stress/injury as much as it is secondary to a functional illness. He would best be served with a rapid return to vocational rehabilitation, training, or employment. This seems to be in agreement with his previous IME evaluation by Dr. Mir of 06/26/01.

The opinions of this examiner may differ from those of other examiners/treating physicians, based on the current clinical evaluation, review of records, or varying degrees of experience, education, and training of the examining population within the field of disability evaluation.

If you should have any further questions please feel free to contact me.

Respectfully submitted,

John D. Justice M.D.

John D. Justice, M.D.
President, CEO & Medical Director
WV Psychiatric & Forensic Services, PLLC
Medical Director Adult Inpatient Psychiatry, Thomas Memorial Hospital
Board Certified American Board of Psychiatry and Neurology
Board Certified Added Qualifications Examination in Forensic Psychiatry

JDJ/bpa:5500

West Virginia Psychiatric Services

400 Division Street, Suite 14
So. Charleston, WV 25309

304-766-4421
Fax 304-766-4461
Jjusticemd@aol.com

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address

CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number: (304) 369-6657

4. Social Security Number: [redacted]3340

5. Date of Birth: [redacted]/1971

6a. Date(s) of last hospitalization
From: _____
To: _____

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written: Chronic low back pain

8a. Type of Prescription
- [X] Original (New)
- [ ] Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 10/10/01
Ending Date: 10/09/02

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

- [ ] Tank O_2 With Flowmeter and Humidifier
- [ ] O_2 Concentrator
- [ ] O_2 Liquid System
- [ ] Portable Unit (Gaseous)
- [ ] O_2 Liquid System With Portable Liquid

9b. Other DME
- [ ] Manual Hospital Bed (11c.)
- [ ] Semi-electric Hospital Bed (11c.)
- [ ] Nebulizer with Motor (11a.)
- [ ] Commode (11f.)
- [ ] Wheelchair (11g.)
- [X] Other (Explain in item no. 12.)

9c. Prescription for Medical Services
- [ ] Pulmonary Rehabilitation Services (See 11e.)
  Level: _____
- [ ] Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. **The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)**

A. Pulmonary Function Test

Date of test: MM DD YY
Pt.'s condition: [ ] Acute [ ] Chronic

Results: (Best Effort)

	Predicted	Bronchodilation Before	Bronchodilation After
FEV_1 L/BTPS			
FVC L/BTPS			

B. *Check as appropriate (if "poor", explain in No. 12 "Additional Comments")*
Miner's Cooperation: [ ] Good [ ] Fair [ ] Poor
Miner's ability to understand instructions and follow directions: [ ] Good [ ] Fair [ ] Poor

C. Was equipment calibrated before the test? [ ] Yes [ ] No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test

Date of test: MM DD YY
Pt.'s condition: [ ] Acute [ ] Chronic

Results:

PO_2	PCO_2	PH

F. Air Intake: [ ] On room air [ ] On O_2 @ ___ LPM

G. Time Sample Drawn _____ Iced [ ] Yes [ ] No Time Sample Analyzed _____

H. Was equipment calibrated before the test? [ ] Yes [ ] No

I. Testing Facility Name and Address

RECEIVED OCT 17 2002

Form CM-893
Rev. Dec. 1990

500688.015.0383

susr/l-5-01/*8 ** VENDOR COPY ** 1024458

Bob Wise
Governor

Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
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an equal opportunity/affirmative action employer

August 29, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - SUSPENSION DECISION

By letter dated 07/16/2001, you were given 30 days to provide medical information to continue payment of your temporary total disability benefits. After again reviewing your claim, it appears there is insufficient information to pay additional temporary total disability benefits and your claim is now closed.

This decision was based primarily on the following: medical repor tof Saghir Mir, MD dated June 26, 2001.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may negotiate a final settlement of any and all issues in a claim, excluding medical benefits. To inquire about settling this claim, contact Workers' Compensation Internal Management Services, Settlement Unit, at P. O. Box 3587, Charleston, WV 25336-3587.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
RIAZ RIAZ UDDIN MD
VASS VOCATIONAL SERVICES

RECEIVED AUG 31 2001

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Bob Wise
Governor

Robert J. Smith
Commissioner

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August 29, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AWARD GRANTED

Medical evidence has been received from Saghir Mir, MD, dated 06/26/2001, that indicates you have a 20% permanent partial disability. You are being granted this award for permanent impairment resulting from your injury.

You will receive monthly payments until your award expires.

The breakdown of your award is as follows:

Current Award $35116.88 Begins 07/16/2001 Expires 01/26/2003

Deductions

NAP Non-Awarded Partial Balance		$0	Total Overpaid	$2765.47
Child Advocate Balance		$3103.97	Balance	$29247.44
Overpaid this claim		$2765.47	Monthly Rate	$1728.84
Overpaid other claims	n/a	n/a		
	n/a	n/a		
	n/a			

The granting of this award closes your claim for permanent partial disability benefits.

If it is later determined you are not entitled to these benefits, you will be directed to reimburse the full amount.

the award is granted as 12% cervical, 5% lumbosacral, 5% left shoulder, 0% ribs and 0% left knee for a 20% combined whole person impairment

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may negotiate a final settlement of any and all issues in a claim, excluding medical benefits. To inquire about settling this claim, contact Workers' Compensation Internal Management Services, Settlement Unit, at P. O. Box 3587, Charleston, WV 25336-3587.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
RIAZ RIAZ UDDIN MD
VASS VOCATIONAL SERVICES

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Governor

Robert J. Smith
Commissioner

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August 29, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - OVERPAYMENT

It appears you have been overpaid in the amount of $ 2765.46 for the period from 07/16/2001 through 8/26/2001, for the following reason(s):

claimant was found to be at maximum medical improvement and temporary benefits suspended by letter dated 07/16/2001

If you cannot repay the full amount to the Division, arrangements must be made for a repayment plan. Failure to repay will result in the deduction of the overpayment from any future permanent partial disability benefits you may receive.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
RIAZ RIAZ UDDIN MD
VASS VOCATIONAL SERVICES

RECEIVED AUG 31 2001

RECEIVED AUG 31 2001

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Cecil H. Underwood
Governor
William F. Vieweg
Commissioner

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• Unemployment Compensation • Workers' Compensation
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January 10, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

PLEASE READ CAREFULLY - PPD RECOMMENDATIONS

A medical report from Saghir Mir, MD, dated 12/28/2000, indicates that you are not ready for a final rating. The examiner recommends:.

recommendations are for follow-up with Dr. Loimil after MRI of shoulder, psychiatric and pain management referral

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

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Cecil H. Underwood
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William F. Vieweg
Commissioner

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January 10, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from WCD-CLAIM MANAGER dated 12/28/2000, is Approved.

authorization to refer for follow-up with Dr. Loimil after MRI of shoulder, referral for psychiatric evaluation, if the treating physician concurs

Authorized Dates are 01/09/2001 through 04/09/2001.

Your authorization number is 101009289.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5097.
Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC

KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED JAN 1 1 2001

[redacted] LIFE INSURANCE COMPANY
P.O. Box 2608 Waco, Texas 76797

1. Claim Form Must Be Completed By INSURED, DOCTOR and, for disability claims only, the EMPLOYER.
2. Mail With The Claim Form All Itemized Doctor and Hospital Bills.
3. Mail The Form In Yourself. Do Not Leave It For The Doctor To Mail.

PART A CLAIMANT'S STATEMENT TO BE COMPLETED ON ALL CLAIMS

Policy Number [redacted]

Policyowner's name and address: [redacted] Sr — P.O. Box 113

Policyowner's employer: [redacted] — Danville, WV 25053

Policyowner's union and local:

Policyowner's occupation: Truck Driver

Patient's name: Christopher W. Lester Sr.

Names of other insurance companies which cover this claim: Medical Insurance a Cordia

Patient's birthdate: [redacted] Relation to policyowner: Self

List the names and addresses of doctors consulted for this accident or sickness and dates of treatment.

DOCTOR	ADDRESS	DATES

If hospitalized, name and address of hospitals and dates of confinement.

HOSPITAL	ADDRESS	DATES
Boone Memorial	701 Madison Ave	11-30-00
	Madison WV 25130	12-4-00

Date that symptoms first appeared: 11-30-00

Date of first treatment by doctor: 11-30-00

Nature of accident or illness: Broke L bruised Rib + back

If an accident, how did it happen? Went to feed our dogs + they growled but + I fell on the steps

Date of accident: 11-30-00

Have you ever had symptoms of this condition before? ☐ Yes ☒ No When?

Are required to give up work

Date returned to work

List all sickness or injuries for which treatment was required in the past five years.

CONDITION	DATE	CONDITION	DATE	CONDITION	DATE

Any person who knowingly and with intent to defraud any insurance company [illegible] is a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Claimant's Signature X Christopher W. Lester Sr.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

Patient's Signature X Christopher W. Lester Sr. Date 1-5-2001

P.O. Box 113 Danville Phone # (304) 369-6657

500688.015.0389

PART B **ATTENDING PHYSICIAN'S STATEMENT**

Patient's name: Christopher W. Lester Sr.	Patient's address: P.O. Box 1113 Danville, WV 25130
Patient's date of birth: [redacted]	
Diagnosis and Concurrent Conditions: (If diagnosis code other than International Classification of Diseases, give name)	Does condition arise out of patient's employment? ☐ Yes ☐ No
	If condition due to pregnancy, date pregnancy commenced

Date of Services	Place of Services	Description of Surgical or Medical Services	Procedural Code (Give name if not current Procedural Terminology)	Charges
	See Attached Bill			
			TOTAL CHARGES	

If hospitalized, name and address of hospitals and dates of confinement

HOSPITAL	ADDRESS	DATES
	Madison, WV 25130	

Date symptoms first appeared: 11/30/00	Result of an accident? A fallen step at home ☒ Yes ☐ No
Date patient first consulted you for this condition: 12/01/00 in hospital visit	Patient still under your care for this condition? ☐ Yes ☐ No
Patient ever had same or similar condition? ☒ Yes ☐ No If yes, when?	Describe same or similar condition: Fall aggravated existing back & neck strain
Patient was continuously TOTALLY DISABLED (unable to work) FROM 11-30-00 TO 12-12-00 For this condition	Patient was PARTIALLY DISABLED FROM: TO
If still disabled, date patient should be able to return to work	Does patient have other health coverage? ☒ Yes ☐ No

Name of other health coverage: Medicaid

Physician's Name (please print): J. Mark Snyder, DO

Physician's Address:

Date: 01-18-2001 Phone #: 369-5170 Signature of Physician: X J Mark Snyder (JS)

PART C **EMPLOYER'S STATEMENT**
(only necessary for Disability Benefit)

Employee's name	Occupation
When did sickness commence or accident occur? Date ☐ AM ☐ PM	When did he/she cease work? Date ☐ AM ☐ PM
If injured, how did accident happen?	
When did employee resume any part of employee's work, supervisory or otherwise? Date ☐ AM ☐ PM	
Firm Name: Phone #:	
Street Address: City: State: Zip:	

500688.015.0390

auth/09-24-98/*8 ** VENDOR COPY ** 1024458

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

January 3, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from MADISON MEDICAL PLLC dated 12/29/2000, is Approved.

authorization for the medication Oxycontin 40mg ***FURTHER CONSIDERATION IS PENDING THE RESULTS OF PAIN MANAGEMENT EVALUATION WHICH WAS AUTHORIZED ON 11/29/2000***

Authorized Dates are 01/02/2001 through 02/02/2001.

Your authorization number is 101002052.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, yWorkers' Compensation Division7.
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED JAN 0 5 2001

RECEIVED JAN 0 [illegible] 2001

extt/01-01-96/*6 ** VENDOR COPY ** 1024458

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Governor

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January 3, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - NOTICE OF BENEFITS

I have received medical evidence which indicates you continue to be disabled from working from 07/01/2000 through 02/27/2001.

If it is later determined you are not entitled to benefits or expenses, the Division may recover these overpayments.

If medical evidence showing continued disability is not received, your claim may close for temporary total disability benefits on 04/13/2001.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
By: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED JAN 0 5 2001

VERBAL BY FREPH

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address
CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number: (304) 369-6657

4. Social Security Number: [redacted]-3340

5. Date of Birth: [redacted]1971

6a. Date(s) of last hospitalization
From:
To:

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written:
lumbar sprain
847.2

8a. Type of Prescription
- [X] Original (New)
- [ ] Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 12/28/00 Ending Date: 12/27/01

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

10a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

- [ ] Tank O_2 With Flowmeter and Humidifier
- [ ] O_2 Concentrator
- [ ] O_2 Liquid System
- [ ] Portable Unit (Gaseous)
- [ ] O_2 Liquid System With Portable Liquid

10b. Other DME
- [ ] Manual Hospital Bed (11c.)
- [ ] Commode (11f.)
- [ ] Semi-electric Hospital Bed (11c.)
- [ ] Wheelchair (11g.)
- [ ] Nebulizer with Motor (11a.)
- [X] Other (Explain in Item no. 12.)

10c. Prescription for Medical Services
- [ ] Pulmonary Rehabilitation Services (See 11e.) Level: _____
- [ ] Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test

Date of test: MM DD YY

Pt.'s condition:
- [ ] Acute
- [ ] Chronic

Results: (Best Effort)

	Predicted	Bronchodilation	
		Before	After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (If "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: [ ] Good [ ] Fair [ ] Poor
Miner's ability to understand instructions and follow directions: [ ] Good [ ] Fair [ ] Poor

C. Was equipment calibrated before the test? [ ] Yes [ ] No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test

Date of test: MM DD YY

Pt.'s condition:
- [ ] Acute
- [ ] Chronic

Results:

PO_2	PCO_2	PH

F. Air Intake: [ ] On room air [ ] On O_2 @ ____ LPM

G. Time Sample Drawn _____ Iced [ ] Yes [ ] No Time Sample Analyzed _____

H. Was equipment calibrated before the test? [ ] Yes [ ] No

I. Testing Facility Name and Address

Copied 9/10/01

Form CM-893
Rev. Dec. 1990

11. DOL/DCMWC REIMBURSEMENT STANDARDS

11a. **For nebulizer equipment with compressor motor:** requires Pulmonary Function Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11h).

11b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

11c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

11d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

11e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

11f. **Commodes:** will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment. **Objective test requirements:** for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

11g. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

11h. **ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:
RIB BELT

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)
JOHN SNYDER
705 MADISON AVENUE
MADISON, WV 25130
(304)369-5170

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☒ No ☐

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 12/29/00 (MM DD YY)

d. Date that the prescribed treatment or service is authorized to begin: 12/29/00 (MM DD YY)

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (DO not use stamp) — Date: 1-4-01

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL FREE: 1-800-638-7072. (In MD.: 1-800-492-8737)

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:
BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
(304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

* * * Transmission Result Report (MemoryTX) (Dec. 29. 2000 2:54PM) * * *

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
6411	Memory TX	13049266092	P. 2	OK	

Reason for error
E.1) Hang up or line fail
E.2) Busy
E.3) No answer
E.4) No facsimile connection

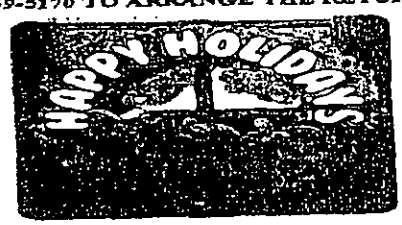
MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp attn Nena Peay
FROM: [illegible]
RE: Christopher Lester 2000046841
NUMBER OF PAGES INCLUDING COVER SHEET: 2
DATE: 12-29-00
ADDITIONAL COMMENTS: Pls auth.

CONFIDENTIALLY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE: (304) 369-5170 TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US.

THANK YOU.



MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp attn Nena Peay

FROM: Debbie

RE: Christopher Lester 200004684/

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 12-29-00

ADDITIONAL COMMENTS: Rx auth.

CONFIDENTIALLY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE: (304) 369-5170 TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US.

THANK YOU.

FAXED 12/29/00

500688.015.0396

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170

WV Worker's Compensation
P. O. Box 431
Charleston, WV 25322-0431

To Whom It May Concern:

Please authorize the purchase of the following medications for this patient for the treatment of his/her compensable injury.

Sincerely, Debbie / Dr. J. Mark Snyder

Patient: Christopher Lester 2000046841

SSN: [redacted]3340

DOI: 3-10-00

RX'S Oxycontin 40mg TID
Increase in dosage

For the treatment of : 847.0

FAXED 12/29/00 KA

auwh/01-01-96/*6 ** VENDOR COPY ** 1024458

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner

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• Job Service/Job Training Programs • Labor Market Information
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November 29, 2000

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION WITHHELD

The request from J. Mark Snyder, DO, dated 11/20/2000, for Ativan 1mg is withheld pending detailed medical report showing the medical necessity in relation to the compensable injury.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

12/5/00 mailed copy of ltr
note 10/11/00 & 11/20/00 E of Dispute letter

RECEIVED NOV 30 2000

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Cecil H. Underwood
Governor

William F. Vieweg
Commissioner

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November 29, 2000

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from LOIMIL LUIS A MD dated 10/17/2000, is Approved.

authorization for MRI left shoulder to rule out rotator cuff tear

Authorized Dates are 11/28/2000 through 02/28/2001.

Your authorization number is 100333285.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, yWorkers' Compensation Division7.
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

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MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Metro MRI

FROM: Freda/ Dr Snyder

RE: Chris Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 3

DATE: 12-28-00

ADDITIONAL COMMENTS:

THANK YOU.

FAXED 12-28-00 JC

500688.015.0400

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Pain Management

FROM: Freda/ DeSnyder

RE: Chris Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 22

DATE: 12-27-00

ADDITIONAL COMMENTS:

THANK YOU.

FAXED 12-27-00 JS

500688.015.0401

MADISON MEDICAL, P.L.L.C
705 MADISON AVE.
MADISON, WV 25130
(304)369-5170 FAX#(304)369-1742

[redacted]/21 PATIENT NAME: Christopher Lester ACCT# 49564

DX: ~~Dx~~ anxiety/depression

INSURANCE: Work Comp

AUTHORIZATION#: #3000025OS

REFERRING DOCTOR: 3

PHONE#: 369-6657 CONTACT NAME: _____

REQUEST FOR: psych consult

_____

SCHEDULED WITH: Dr. Riay (1st choice)

DATE/TIME: March 28-Wed 732-9132
10:45am

attn Gloria
~~RECORDS~~ W-C Auth

_____ SENT BY MAIL

3/14/01 FAXED 732-6589

_____ GIVEN TO PT TO HAND DELIVER

3-14-01 PT WAS NOTIFIED OF DATE, TIME AND ANY SPECIAL INSTRUCTIONS.

3/13/01 LmaAm

Attending Physician' Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

WC-219 Rev. 9-94

FOR DIVISION USE ONLY
Claims Manager Nena Peay
Trucking/Agr & Food Prop
Claimant's County BOONE

1. Claim No. 2000046841
Emp. Fisk No. 98001651
Claimant's Name and Address

SS No. [redacted]3340
DOI 03/10/2000

2. Current Telephone No. 304-369-6657

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address

D & N TRUCKING CORPORATION
PO BOX 116
GHENT, WV 25843-0116

3. *Please mark any needed changes in your address as printed above.*

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature _____ Date _____

SECTION B: To be completed by the Attending Physician (MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY ONLY)

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 11/22/00 (Month Day Year)

2. Date of next appointment ___ (Month Day Year) F/U after eval at Pain Management

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☒ No If Yes, please advise as to how the claimant came under your care. _____

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain. _____

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☒ Consultation ☒ Evaluation ☒ Treatment Dr Leimi / Pain Management / Dr Settle

4. Diagnosis (ICD9-CM) code and description
847.0 847.2
847.1 959.01

5. Please describe your treatment plan and list medications currently being prescribed, their dosages and the refill limit.
maintain oral meds
eval by pain management

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequ trauma, etc? ☐ Yes ☒ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☒ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due t compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ___ Trial Return to Work 2/28/01 Full-time Work ___

10. If the claimant has reached maximum medical improvement, is there, or do you anticipate, any permanent impairment as a result of th compensable injury? ☐ Yes ☐ No If Yes, please complete form WC-219a, Notice of Maximum Medical Improvement.

11. Physician's Name, Address & Telephone No.
MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130
Phone: 304-369-5170
FEIN 550664546

12. _____ Physician's Signature
10/28/00 Date

Copied 12-20-00

INTRACORP

12/01/2000

JOHN SNYDER
705 MADISON AVENUE
MADISON, WV 25130

Patient:	CHRISTOPHER LESTER
Payor:	ACORDIA NATIONAL
Plan Participant:	APRIL LESTER
Participant ss#:	[redacted]9969
Policy #:	
Employer:	WV PEIA
Case Reference #:	21583411
Facility:	BOONE MEM HOSP
Admit Date:	11/30/2000

This inpatient admission is subject to the Health Care Payor's Inpatient Review program with Intracorp.

The admission has been authorized as medically necessary so this satisfies the requirements of the program.

We may need to contact the treating physician periodically during the hospital stay to discuss this patient's progress. Please notify us at the number below if there is any change in the scheduled date of admission or discharge so that we can review the date for contacting the treating physician accordingly.

The treating physician, health care payor, and hospital business office have been notified of this determination. By contract with its customer, Intracorp must review all services and treatments for plan participants. Benefits are subject to eligibility requirements and contract limitations and must be verified with the health care payor.

Sincerely,

DONNA COOK

CC:
ACORDIA NATIONAL
APRIL LESTER
BOONE MEM HOSP

SOUTHEAST SERVICE CENTER
3567 PKWY LN
STE 200
NORCROSS, GA 30092
(888)440-7342

500688.015.0404

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November 29, 2000

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from MADISON MEDICAL PLLC dated 11/20/2000, is Approved.

authorization for the medication Oxycontin 10mg and referral for pain clinic evaluation

Authorized Dates are 11/20/2000 through 02/20/2001.

Your authorization number is 100333280.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, yWorkers' Compensation Division7.
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED NOV 30 2000

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500688.015.0405

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Cecil H. Underwood
Governor

William F. Vieweg
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November 29, 2000

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - NOTICE OF BENEFITS

I have received medical evidence which indicates you continue to be disabled from working from 07/01/2000 through 12/26/2000.

If it is later determined you are not entitled to benefits or expenses, the Division may recover these overpayments.

If medical evidence showing continued disability is not received, your claim may close for temporary total disability benefits on 02/09/2001.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
By: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED 30 2000

Workers' Compensation Division - Office of Claims Management

500688.015.0406

appt/01-01-96/*8 ** VENDOR COPY ** 1024458

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

November 29, 2000

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - APPOINTMENT SCHEDULED

You have been scheduled for an appointment on DECEMBER 22,2000, at 10:30AM with:

MIR SAGHIR MD Phone: 304-442-5176
P O BOX 839
MONTGOMERY, WV 25136

The above named physician should provide the Division with a narrative report which outlines your medical history, diagnostic studies, physical examination, diagnosis, and prognosis. The following questions should be answered:

1. Has the claimant reached maximum medical improvement? (No additional surgical or medical intervention will change the claimant's condition.)
2. Is the claimant working? If so, in what capacity? If not, could the claimant return to a modified work assignment and with what restrictions?
3. What impairment rating is recommended, using the AMA Guide to the Evaluation of Permanent Impairment, Fourth Edition?

If the claimant has not reached maximum medical improvement, what additional diagnostic studies and/or treatment do you recommend and what benefit should be expected? (Review the WCD Treatment Guides for the diagnosis before making your recommendations.)

This exam was scheduled by the Division and all bills and related expenses should sent to us.

THIS EXAM WAS REQUESTED BY YOUR CLAIMS MANAGER, NENA PEAY

Failure to keep this appointment may result in the closing of your claim for benefits.

If you have any questions or concerns, you may reach me at 800-628-4265.

Workers' Compensation Division
BY: Lavonne Salmons
Independent Med Ex

CC: D & M TRUCKING CORPORATION INC
MIR SAGHIR MD
KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED NOV 30 2000

RECEIVED [illegible] 30 2000

MADISON MEDICAL, P.L.L.C
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Rena Peay / Workers Comp.

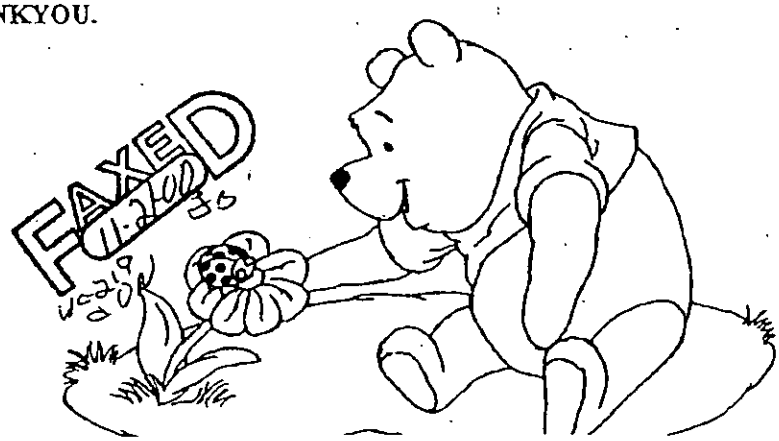
FROM: Freda / Dr Snyder

RE: Christopher Lester #200046841

NUMBER OF PAGES INCLUDING COVER SHEET: 3

DATE: 11-21-00

ADDITIONAL COMMENTS: Pt to bring in original to Comp office.



500688.015.0408

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

WC-219 Rev. 9-94

DIVISION USE ONLY
Claims Manager Nena Peay
Trucking/Agr & Food Proc
Claimant's County BOONE

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED)

1. Claim No. 2000046841 SS No. [redacted]3340 2. Current Telephone No. 304-369-6657
Emp. Fisk No. 98001651 DOI 03/10/2000

Claimant's Name and Address

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address

D & M TRUCKING CORPORATION
502 BOB VINES RD
GHENT, WV 25843

3. ***Please mark any needed changes in your address as printed above.***

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☑ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature Christopher W. Lester Date 11-20-00

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 11/14/00 (Month Day Year) 2. Date of next appointment 11/27/00 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☒ No If Yes, please advise as to how the claimant came under your care.

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain.

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☒ Consultation ☒ Evaluation ☒ Treatment

4. Diagnosis (ICD9-CM) code and description
847.0 847.2
847.1 959.01

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
continue meds request Pain Clinic Evaluation

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☒ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☒ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work 12/27/00 Full-time Work ____

10. If the claimant has reached maximum medical improvement, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form WC-219a, Notice of Maximum Medical Improvement.

11. Physician's Name, Address & Telephone No.

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

Phone: 304-369-5170

FEIN 550664546

12. [signature] Physician's Signature

11-17-00 Date

P. 1

* * * Transmission Result Report (MemoryTX) (Nov.20. 2000 3:49PM) * * *

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
4909	Memory TX	13049266092	P. 2	OK	

Reason for error
E.1) Hang up or line fail
E.2) Busy
E.3) No answer
E.4) No facsimile connection

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

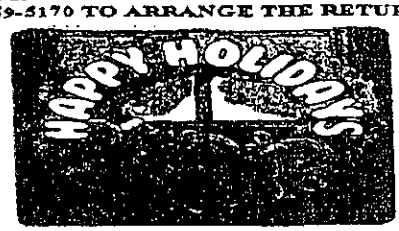
FAX COVER SHEET

TO: Workers Comp attn: Rena Reay
FROM: Debbie / Dr. J. Mark Snyder
RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2
DATE: 11-20-00
ADDITIONAL COMMENTS: Rx Auth.

CONFIDENTIALLY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE: (304) 369-5170 TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US.

THANK YOU.



500688.015.0410

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170

WV Worker's Compensation
P. O. Box 431
Charleston, WV 25322-0431

To Whom It May Concern:

Please authorize the purchase of the following medications for this patient for the treatment of his/her compensable injury.

Sincerely, Dr. J. Mark Snyder

Patient: Christopher Lester 2000046841

SSN: [redacted] - 3340

DOI: 3/10/2000

RX'S Ativan 1mg TID
Oxycontin 10mg TID

For the treatment of: 847.0

FAXED 11-20-00

500688.015.0411

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp attn: Rena Peay

FROM: Debbie / Dr. J. Mark Snyder

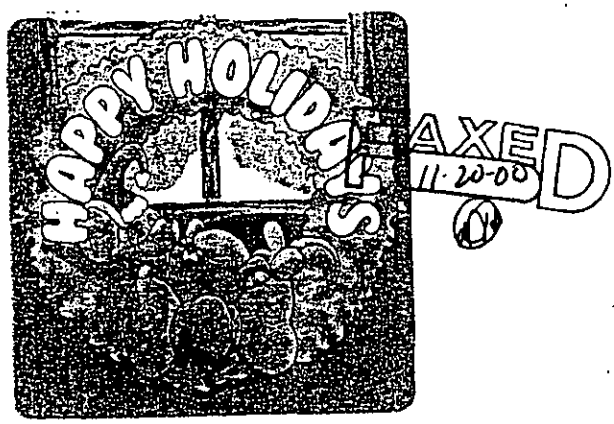
RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 11-20-00

ADDITIONAL COMMENTS: Rx Auth.

THANK YOU.



500688.015.0412

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

WC-219 Rev. 9-94

DIVISION USE ONLY
Claims Manager Nena Peay
Trucking/Agr & Food Proc
Claimant's County BOONE

1. Claim No. 2000046841 SS No. [redacted]-3340
Emp. Risk No. 98001651 DOI 03/10/2000
2. Current Telephone No. 304-369-6657

Claimant's Name and Address

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address

D & M TRUCKING CORPORATION
502 BOB VINES RD
GHENT, WV 25843

3. ***Please mark any needed changes in your address as printed above.***

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature _____ Date _____

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 11/14/00 (Month Day Year)
2. Date of next appointment 11/27/00 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☒ No If Yes, please advise as to how the claimant came under your care. _____

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain. _____

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☒ Consultation ☒ Evaluation ☒ Treatment _____

4. Diagnosis (ICD9-CM) code and description
847.0 847.2
847.1 959.01

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
continue med request Pain Clinic Evaluation

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☒ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☒ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ___/___/___ Trial Return to Work 12/27/00 Full-time Work ___/___/___

10. If the claimant has **reached maximum medical improvement**, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form **WC-219a, Notice of Maximum Medical Improvement.**

11. Physician's Name, Address & Telephone No.
MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130
Phone: 304-369-5170
FILE COPY
FEIN 550664546

12. [signature]
Physician's Signature
11-17-00
Date

500688.015.0413

VALLEY ORTHOPAEDIC SURGEONS L.L.C.
LUIS A. LOIMIL, M.D.
FID: 311568166

3510 MacCorkle Ave., S.E.
Charleston, WV 25304

(304) 925-6961
FAX (304) 925-2619

NAME LESTER, Christopher W.
ADDRESS P.O. Box 1113
Danville WV 25053
PHONE (304) 369-6657
RESPONSIBLE PARTY Christopher W.
EMPLOYER (1) D&M Trucking
(2)
EMPLOYER'S ADDRESS & PHONE #

AGE 28 SEX M DOB [redacted]71
SS [redacted]3340
MARITAL STATUS M SPOUSE'S NAME April
DOI 03/10/2000
INSURANCE WV Workers' Comp 2000046841
REFERRED BY John M. Snyder, D.O./Workers' Comp
Dx (L) SHOULDER - Rotator cuff injury

10/17/2000 - Office

C. COMPLAINT: One time consultation per the request of John M. Snyder, D.O. and authorized by Nena Peay, Claims Rep. at Workers' Comp by letter dated 08/21/2000, authoz. #100231133 regarding pain in the (L) shoulder.

INTRODUCTION: Mr. Lester works as a truck driver for D&M Trucking. His date of injury was 03/10/2000; he has been off work since that date and states he has filed for disability Social Security. His attorney is Stuart Calwell. The last doctor he saw for this condition was Dr. Snyder, his PCP in Madison WV some time around 10/09/2000 for follow-up of his neck and back; to return in two weeks.

HPI & RECORD REVIEW: Mr. Lester states that on 03/10/2000 he was at work when he fell off a truck, injuring his (L) shoulder, mid back and ribs. He apparently lost consciousness. He was taken to the e.r. at CGH where x-rays were taken and he was referred to HealthPlus; he was treated there for two weeks and was then referred to Dr. Snyder, his family physician who he saw on 04/07/2000. He was referred for PT treatments at Boone Mem. Hosp. which helped. He had the x-rays repeated on 08/30/2000 and a MRI was done on 09/12/2000. Dr. Snyder now requested this consultation regarding his (L) shoulder.

On review of the records there is an x-ray report of the cervical spine dated 03/10/2000 at CAMC and these are within normal limits. There is an x-ray of the (L) shoulder, same date and this was normal. X-rays of the lumbar spine, same date, are normal. CT-scan of the cervical spine, same date, showed no evidence of acute fracture or subluxation.

OVER.....

CHRISTOPHER W. LESTER
SS: [redacted]3340
BD: [redacted]71

WV WORKERS' COMP
CLAIM #: 2000046841
DOI: 03/10/2000

10/17/2000 cont'd: There is a report from Dr. Snyder dated 04/07/2000; his diagnosis was cervical and lumbar strain as well as (L) shoulder strain and contusion. He was placed on conservative care with Motrin, Flexeril and Vicodin and PT. There is another note from him dated 04/20/2000; pretty much the same. He was seen again on 04/26/2000; the same. On 05/10/2000 nothing had changed; he continued to have trouble with his shoulder. He was seen again on 05/24/2000 and was doing about the same. He was advised to continue with PT and an appt. was requested with me for evaluation of his (L) shoulder. There is another note dated 06/09/2000; to continue with the same treatment. On 06/21/2000 he was advised to discontinue the PT treatments. On 07/10/2000 he was awaiting the consultation with me; same for 07/31/2000. On 08/28/2000 he was scheduled to have a MRI done. He was seen again on 09/05/2000 and was doing the same. On 09/13/2000 the report states a MRI and EMG were pending. On 09/26/2000 he stated the MRI was negative. On 09/29/2000 he refers to ongoing low back pain, anxiety and depression.

I reviewed PT progress notes dated 04/20/2000 through 06/19/2000; these are signed by Tricia McClung, PT. The note dated 06/19/2000 states the patient continues to report neck, low back and (L) shoulder pain with no significant increase in the ROM.

On 08/02/2000 he was evaluated by Saghir R. Mir, M.D. His recommendations were orthopaedic and neurosurgical consults as well as consult for pain management. He recommended PT for the neck, back and (L) shoulder and he deferred his impairment rating.

I reviewed an x-ray report of the (L) shoulder taken at Boone Mem. Hosp. on 08/30/2000; this was done with and without weights and there was no evidence of AC separation.

I reviewed a report of a MRI done at Boone Mem. Hosp. on 09/12/2000; the cervical spine was normal and the lumbar spine was normal. Apparently there is an EMG pending; I do not have the report or know if it has even been done yet.

REVIEW OF SYSTEMS:

HEENT - He was involved in a motorcycle accident in 1987 and sustained a cerebral concussion and was unconscious for two days.

PULMONARY - He has asthma.

OVER.....

CONTINUATION of RECORD on CHRISTOPHER W. LESTER
Page Two
SS: [redacted]-3340
BD: [redacted]71

WV WORKERS' COMP
CLAIM #: 2000046841
DOI: 03/10/2000

10/17/2000 cont'd: CARDIO CIRCULATORY - Negative.
GASTROINTESTINAL - He has question of irritable bowel syndrome.
GENITOURINARY - Negative.
MUSCULOSKELETAL - Neck, back and (L) shoulder pain.
NEUROPSYCHIATRIC - He was seen by Dr. Amores on 10/03/2000 for a consultation regarding his neck and back and he was told to have a strain.

He denies previous psychiatric treatment.

PRESENT CONDITION & COMPLAINTS: He has pain in his (L) shoulder and numbness in his ring and little fingers and down the lateral aspect of his arm. He has shooting pain deep in the shoulder and he cannot apply pressure without pain. He has decreased ROM. He states he needs to use a cane in his (L) hand but is unable to. He has pain in his sholder blade up into his neck area.

HEALTH & SOCIAL HISTORY:
AGE: Twenty-eight.
MARITAL STATUS: Married.
CHILDREN: Three.
EDUCATION: High school graduate.
ALCOHOL: No.
TOBACCO: No.
GENERAL HEALTH: Good.

HEIGHT: 5'8"
WEIGHT: 284 lbs.
METAL: None.
MEDICATIONS: Paxil, Ativan, Vicoden ES, OxyContin, Vioxx, Flexeril & Motrin.
ALLERGIES: None.
FAMILY PHYSICIAN: Dr. John Snyder.

He is (R) handed.

DAILY LIVING ACTIVITIES: SELF CARE & PERSONAL HYGIENE - He has difficulty going to the bathroom and unbuttoning his pants.
EAT & PREPARE FOOD - He has trouble eating with his (L) hand; he is (R) handed.

OVER.....

CHRISTOPHER W. LESTER
SS: [redacted]3340
BD: [redacted]/71

WV WORKERS' COMP
CLAIM #: 2000046841
DOI: 03/10/2000

10/17/2000 cont'd: COMMUNICATION: SPEAK & WRITE - Pain in (R) arm with writing.
POSTURE: STAND & SIT - He has pain in his back and (L) shoulder and numbness of his (L) arm.
CARING FOR THE HOME & PERSONAL FINANCES - He has to have a babysitter for his children even though he is home.
WALK, TRAVEL & MOVE ABOUT - His knees give way and he has back pain.
RECREATIONAL & SOCIAL ACTIVITIES - None.
WORK ACTIVITIES - He is not working at the present time.

PAST INJURIES: He states he had a previous injury to his thoracic spine in 1994 from a mobile home accident.

WORK HISTORY: He has worked for D&M Trucking since October 1998. He has done logging, mine supply delivery and worked in a hardware store.

WORK DESCRIPTION: He hauls coal, climbs on a truck, changes tires, rolls and loads tarp and pushes coal off.

EXAM: On examination of the (L) shoulder he is walking with a cane in his (R) hand due to his other injuries. He is tender on palpation of the entire (L) shoulder, especially the rotator cuff. The grip strength is 60-55-55 kilograms in the (R) and 15-12-10 in the (L). The pinch strength is 8-8-8 kilograms in the (R) and 3-3-3 in the (L). The (R) upper arm measures 41½ centimeters in circumference; the (L) is 40. The (R) forearm measures 33½ centimeters in circumference; the (L) is 31. He is (R) handed.

Regarding the ROM of the (L) shoulder abduction is 50 degrees and adduction is 20; flexion is 40 degrees and extension is 30; internal rotation is 70 degrees and external rotation is 40. He has a full ROM of his elbow and wrist with pain. He has numbness in the ulnar nerve territory with a positive Tinel sign in the (L) elbow. He has obvious weakness of abduction of his (L) shoulder and pain in the rotator cuff area.

X-RAYS: I reviewed x-rays taken at Boone Mem. Hosp. on 08/30/2000. The (L) AC joint is within normal limits and the (L) shoulder is within normal limits.

DX: It is my impression that due to the persistance of the pain, limitation of the ROM and weakness of abduction, he could have a rotator cuff injury with tear.

OVER.....

CONTINUATION of RECORD on CHRISTOPHER W. LESTER
Page Three
SS: [redacted]-3340
BD: [redacted]/71

WV WORKERS' COMP
CLAIM #: 2000046841
DOI: 03/10/2000

10/17/2000 cont'd: Due to the inability to ascertain a tear of the rotator cuff on x-rays, I feel he needs to have a MRI done of the (L) shoulder. I will accept him in transfer for treatment of his (L) shoulder if that is what you want me to do and if this is authorized, please authorize the MRI. The plan of treatment will be determined after the results of the MRI are obtained.

REVIEW OF RECORDS: In preparing this report I reviewed the following records:

1) X-ray, CT-scan & MRI reports from Boone Mem. Hosp. dated 03/10/2000, 04/10/2000, 08/30/2000 and 09/12/2000;
2) Records from Dr. Snyder dated 04/07/2000 through 09/29/2000;
3) Dr. Mir's IME report, dated 08/02/2000.

This evaluation was done following the Rules & Regulations of WV Workers' Compensation, in the presence and with the cooperation of Tammy Hylenski, Med Tech.

Luis A. Loimil, M.D./dr

NOTE: 11/16/2000 - Copy of report mailed to Workers' Comp and Dr. Snyder.

dr

Luis A. Loimil, M.D.

500688.015.0418